# THE CANADA HEALTH ACT:

# OVERVIEW AND OPTIONS

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# THE CANADA HEALTH ACT: OVERVIEW AND OPTIONS

## ISSUE DEFINITION

1994 marked the 10th anniversary the *Canada Health Act* (hereafter called the Act), which received Royal Assent on 1 April 1984. Through this Act, the federal government ensures that certain national standards, such as free and universal access to insured health care, are met by the provinces and territories. These standards, or basic principles, have shaped the national health insurance plan.

Today, however, the Act is the focus of lively debate. The gradual reduction in federal transfers to provinces, the reform of Established Programs Financing (EPF), talk of imposing user charges, the de-insuring of services previously covered by health insurance, the practice of extra-billing and the existence of semi-private medical clinics in some provinces are all factors that question or can be said to threaten national health standards.

The discussion on national standards is part of a much broader picture, involving factors that are political (separation of powers), fiscal (deficit reduction) and economic (greater cost-effectiveness). It raises fundamental concerns about the public sector's role, including that of the federal government, in health care funding. In this context, the spirit and character of the Act are intrinsically linked to reform of the health sector in Canada.

This document examines the *Canada Health Act* against this background of reform. It does not set out to offer a legal interpretation of the Act; rather, it seeks to take stock of its evolution and examine its future prospects. The first section reviews the justifications for government intervention in the health sector, while the second describes the respective roles of the federal government and the provinces. The third section traces the historical background of the Act, and the fourth presents an overview of the standards and criteria attached to it. In the fifth section, penalties for defaults under the Act are described, and in the sixth and final section, some options are set out for maintaining the Act or improving it.

## BACKGROUND AND ANALYSIS

### A. Justification for Government Intervention in the Health Sector

In Canada, governments are the main source of funding for the health sector since they play a key role in the insurance market. The proponents of government intervention in this field generally cite economic and social equity factors. First, they explain that government intervention is necessary to correct potential problems for social equity in the operation of the private insurance market. They claim that private insurance companies could refuse to insure high-risk clients or force them to pay a much higher premium to offset the risk. They believe that government insurance can correct the shortcomings in the private market by protecting the broadest possible cross-section of the population and avoiding unreasonable premium hikes which ultimately effect no improvement in the state of health. Moreover, they also maintain that the private insurance market does not have a regard for economic equity. They argue that in a private insurance market, individuals with health problems and a low income would be subject to the same fee structure as high-income individuals; thus, economically disadvantaged individuals would have to assume a relatively higher proportion of health care costs. Government intervention would, then, guarantee increased access to insurance, regardless of the individual's ability to pay.

For these reasons, governments in Canada have favoured government health insurance over private insurance. This approach, which protects all people against the risk of illness, is essentially based on income tax: all citizens contribute in accordance with their income, rather than in accordance with the benefits they expect to derive. Thus, since its introduction, the Canadian health insurance system has stressed the principle of transferring resources from the richer to the poorer and spreading the risk over those in good health and those with health problems.

This does not mean, however, that the private sector is totally absent from this field in Canada. Private health insurance exists, but its scope is limited. To be more precise, the private market provides additional coverage for health services that are not insured by the public plan or that are only partially insured by it. Moreover, health service delivery is largely in the hands of the private sector; most medical practitioners are in private practice and hospitals are to a great extent private, non-profit organizations. However, physician and hospital services and remuneration for these are subject to government regulation.

## B. The Role of Governments in Canada in the Health Sector

The federal and provincial governments have very different responsibilities in the health sector. Strictly speaking, the federal government cannot establish and maintain a national health insurance system because it cannot regulate health care delivery to individuals; under the Canadian Constitution, and according to how this has been interpreted by the courts, health is a field primarily under provincial jurisdiction. The only explicit references in the Constitution to health issues give the federal government jurisdiction in matters relating to navy hospitals and quarantine. The federal government maintains health services only for groups that fall under its jurisdiction, such as aboriginal peoples, the people of Yukon, the Canadian forces, veterans and inmates in federal penitentiaries. The provincial governments determine how many beds will be available in their province, what categories of staff will be hired and how the system will serve the population. They also approve hospital budgets, negotiate fee scales with the medical associations and administer their own provincial health insurance program for their own province.

The federal government has intervened in the health care field by using the "spending power," which enables it to make a financial contribution to certain programs under provincial jurisdiction, generally subject to provincial compliance with certain standards. Pierre Blache, in an article published in 1993 in the *Revue générale de droit*, indicates that in his opinion, it is the constitutional imbalance between powers and responsibilities, together with inter-provincial equity factors, that brought about federal transfers such as those that go to the health sector:

> The scale of transfer payments from the federal government to the provincial governments has increased in Canada as a result of the characteristics of the constitution and reality. It is because Canadian provinces have been given the potentially most expensive responsibilities in the modern state, while being limited to direct taxation, and because many of them have found themselves faced with a tax base below the national average, that recourse to the spending power has become so important in the practical workings of Canadian federalism. [...] Against such a background, it appeared unfair to leave it to the provinces to fund the social programs demanded by the people, out of their own resources. (p. 38) [translation]

Consequently, the federal government has intervened in areas under provincial jurisdiction, but without changing the division of powers stipulated in the Constitution. Although the federal government is not responsible for health care administration or delivery, it can exert considerable influence on provincial health policies by using the political and financial leverage afforded by the spending power. In fact, by setting the criteria for providing federal funding, the *Canada Health Act* has to a large extent shaped provincial health insurance programs.

C. Historical Background

The Canadian health insurance plan as we know it today, in which the financial contribution of the federal government is linked to provincial compliance with national standards, dates back to the 1950s. Under the *Hospital Insurance and Diagnostic Services Act of 1957* and the *Medical Care Act of 1966*, the federal government made an offer to the provinces to fund approximately half the cost of all insured health services. In return for federal contributions, the provinces, as part of their public health insurance plans, undertook to insure hospital and physician services and to comply with certain criteria, such as universality and coverage. These two Acts did not prevent provinces from demanding a financial contribution from patients; however, since federal contributions were proportional to provincial government expenditure, the provincial governments had nothing to gain from imposing user charges. In fact, the revenue from such charges would have resulted in a reduction in the federal contribution. This implicit reduction mechanism thus strongly deterred provinces from adopting any form of private fee structure.

In 1977, this formula of shared costs was replaced by a method of block funding based on cash transfers and tax transfers as part of Established Programs Financing (EPF). Both federal Acts on hospital services and medical care and the criteria attached to them were retained. However, the implicit mechanism for deducting federal contributions was eliminated with the EPF, since federal funding was no longer linked to provincial government expenditures; this resulted in a proliferation of private fee structures. For example, Newfoundland, New Brunswick, Quebec, Ontario, Saskatchewan, Alberta and British Columbia levied user charges and extra-billing was authorized in most provinces. The federal government saw this private fee structure as posing a threat to the principle of free and universal access to health services throughout the country. It was

therefore anxious to reassert its commitment to the principles of universal health insurance; it relied heavily on the criterion of economic equity to justify its intervention. A document issued by Health and Welfare Canada in 1983 stated:

> The Government of Canada believes that a civilized and wealthy nation, such as ours, should not make the sick bear the financial burden of health care. Everyone benefits from the security and peace of mind that come with having pre-paid insurance. The misfortune of illness which at some time touches each one of us is burden enough: the costs of care should be borne by society as a whole. That is why the Government of Canada wishes to re-affirm in a new Canada Health Act our commitment to the essential principle of universal health insurance.

This document paved the way for the *Canada Health Act*, which, as we stated earlier, was passed on 1 April 1984. The Act combined and updated the two federal Acts of 1957 and 1966. The national standards were reaffirmed in the Act, but extra restrictions were specifically added to deter any form of user charges and to provide citizens of all provinces with access to health care regardless of ability to pay.

**Starting on 1 April 1996, the *Canada Health Act* was linked to a new method of block funding, a departure from EPF. Under the *Budget Implementation Act, 1995*, and the *Budget Implementation Act, 1996*, EPF transfers were merged with those of the Canada Assistance Plan (CAP) to form a single funding mechanism called the Canada Health and Social Transfer (CHST). The method of calculation adopted for the CHST includes both cash transfers (which have a minimum floor of $11 billion until 2002-03) and transfers of tax points.**

D. The Criteria Stipulated in the Act

The *Canada Health Act* lists the criteria that provincial governments must meet as part of their health insurance plan to qualify for federal contributions. These criteria are universality, comprehensiveness, accessibility, portability and public administration. The Act also contains specific provisions on extra-billing and user charges.

The first national standard is stipulated in section 8 and deals with public administration. Under this section, each provincial health insurance plan must be administered on a non-profit basis by a public authority, which is accountable to the provincial government for its financial transactions. This arrangement is largely explained by the considerable amount of money devoted to the health sector and the need for governments to keep some control over the growth of these expenditures. It is also designed to allow information to be consolidated.

Under the criterion of comprehensiveness stipulated in section 9, the health insurance plan of a province must insure all services that are "medically necessary." The criterion of comprehensiveness refers in a way to a minimum basket of services, since the Act neither mentions the quantity of services to be provided nor gives a detailed list of what services will be insured; provincial governments can define these. Thus, the range of insured services may vary among provinces and from one year to the next.

Under section 10, the principle of universality demands that all residents in the province have access to public health insurance and insured services on uniform terms and conditions. Initially, the concept of universality focused on two specific objectives. First, it sought to make insured services available to everyone, everywhere. Second, it sought to spread the risk among those insured; the more people the plan covered, it was said, the more the risk-sharing would be cost-effective.

As stipulated in section 11, the condition of portability requires provinces to cover insured health services provided to their citizens while they are temporarily absent from their province of residence or from Canada. For insured health services provided in another province, payment is made at the rate negotiated by the governments of the two provinces. For out-of-Canada services, the Act states that the amount paid will be at least equivalent to the amount the province of residence would have paid for similar services rendered in that province.

The fifth main principle is set out in section 12 and deals with accessibility: insured persons must have reasonable and uniform access to insured health services, free of financial barriers. Free access is the key factor in the Act, which specifically prohibits any direct or indirect financial barrier; sections 18 to 21 of the *Canada Health Act* limit the financial contribution of

patients, either through user charges or extra-billing, for health services insured by a provincial health insurance plan.

The national standards and provisions relating to extra-billing and user charges apply only to insured health services, those that have been deemed "medically necessary," and not to "extended health care services." So-called medically necessary services are defined only in the broad sense of the term in the Act; section 2 states that insured health services comprise (1) hospital services that are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability, including, accommodation and meals, physician and nursing services, drugs and all medical and surgical equipment and supplies; (2) any medically required services rendered by medical practitioners; and (3) any medically or required surgical-dental procedures which can only be properly carried out in a hospital. These services must be fully insured by provincial health insurance plans.

Under section 2 of the Act, extended health care services include intermediate care in nursing homes, adult residential care service, home care service and ambulatory health care service. Since these services are not subject to any conditions, they can be charged for at either partial or full private rates. In addition, provincial health care insurance plans may cover other extended services, such as optometric services, dental care and drugs, which are also not covered by the Act, and for which provinces may demand payment from patients. The range of extended health care services insured by provincial government plans, the rate of coverage and the categories of beneficiaries vary greatly from one province to another.

E. Penalties for Defaults under the Act

The *Canada Health Act* and CHST transfers are intrinsically linked, as was the case with EPF. More precisely, every provincial health insurance plan must comply with the standards stipulated in the Act, as well as the provisions attached to them, before the province receives its total entitlement under the CHST. If a province fails to comply with the criteria stipulated in the Act, the federal government may impose a penalty and withhold part or all of the CHST transfer. Moreover, since 1991, the financial penalties are no longer limited to federal transfer payments for health. **With the reduction in EPF financial transfers, the government has had to expand the penalties to cover other financial transfers.** When the total EPF cash transfer was less than the

amount to be withheld, the federal government could also withhold other transfers--not just EPF payments--if a province violated one of the Act's provisions. **This applies equally to the CHST, but it has become less relevant with the merger of EPF and CAP transfers in a single envelope.** The additional withholdings or deductions are not stipulated in the *Canada Health Act*, but are specifically set out in paragraphs 23.2(1), 23.2(2) and 23.2(3) in the Act governing Established Programs Financing. It became necessary to extend the financial penalty to transfer payments in fields other than health because of the federal government's continued restriction on the growth rate of EPF transfers and its specific impact on cash transfers. According to some studies, such as those conducted by the National Council of Welfare in 1991 and Jenness and McCracken in 1993, EPF payments to some provinces will be non-existent by the year 2000. Thus, the federal government has taken action to prevent the erosion of its power in enforcing compliance with the national standards across the country.

The financial penalties stipulated in the Act vary depending on whether a default is directly related to extra-billing and user charges or involves failure to satisfy any of the five main principles of health insurance. Sections 18 to 21 of the Act, which describe the provisions relating to penalties for extra-billing and user charges, stipulate that the federal government may withhold one dollar of cash transfer for every dollar collected through private fee structures. In the case of failure to satisfy national standards, section 15(1)(a) of the Act stipulates that the cash value of the penalty is left to the discretion of the Governor in Council, who sets the amount depending on the "gravity" of the default. At one extreme, Cabinet could decide to withhold all EPF transfer payments, and even reduce payments paid as part of other programs. At the other extreme, the federal government could decide not to impose any financial penalty and to confine its action to persuasion and negotiation alone. As Sheilah L. Martin suggested in a paper published in 1989, the discretionary nature of this penalty does not require the federal government to impose a fine, but leaves it the option of doing so.

The Act also includes a conflict resolution mechanism for cases where a province violates national standards. It is a long process, however, with the result that federal contributions are not reduced immediately. In the event that Health Canada deems a provincial plan as failing to satisfy any one of the five criteria, under section 14(2), it must inform the province of the problem, obtain its explanations, draft a report on its concerns and, if the provincial Health Minister so

requests, hold a meeting to discuss the issue. Section 15 states that only if the Governor in Council is convinced that the province no longer meets national standards, may Health Canada direct by order that federal contributions be reduced or withheld.

The federal government has already resorted to financial penalties and reduced its contributions to some provinces that were authorizing extra-billing or imposing user charges; it deducted over $85 million from EPF payments during the 1984-85 fiscal year. However, it also complied with section 20(6) of the Act, under which a province was able to recover these funds if it terminated all forms of private fee structures in the three years after the Act came into force, that is, before 1 April 1987. Since all provinces complied with the Act within this timeframe, the amounts withheld were all reimbursed.

In 1994, the federal government once again used the penalties stipulated in the Act. The Governor in Council decided to withhold $1,750,000 in EPF transfer payments to British Columbia because approximately 40 medical practitioners in that province had opted out of the province's health insurance system in 1993 and resorted to extra-billing. These doctors have since discontinued this practice.

More recently, the federal government announced that it would once again impose other financial penalties to ensure compliance with the *Canada Health Act*. In January 1995, the Canada's Minister of Health, the Honourable Diane Marleau, sent a letter to all provincial governments warning them that semi-private clinics that demand facility fees from patients for medically required services are violating the Act, since such charges constitute user fees. This letter gave the provinces until 15 October 1995 to comply with the Act; after this date, the federal government would reduce its transfers by an amount equivalent to the revenue received from user fees. Apparently, the Minister's warning was primarily aimed at Alberta, where it is estimated that private clinics collect between $4 million and $7 million every year in facility fees. There are, however, private clinics in most provinces and, after the 15 October 1995 deadline had passed, the federal Health Minister indicated that the cash penalties would apply to all offending provinces. In November 1995, Health Canada began penalizing Alberta by holding back monthly transfer payments in the amount of $420,000. **The penalty continued to be applied until July 1996, when the province began complying with the Act. Since November 1995, monthly penalties**

**have also been imposed on Manitoba ($49,000), Nova Scotia ($6,000), and Newfoundland ($8,000).**

Until now, however, there has been no discretionary penalty for failure to comply with the major principles stipulated in the Act, despite some complaints regarding certain criteria, primarily portability and comprehensiveness. Further, it is feared that in addition to violating the provisions on user charges, private clinics are undermining the principle of accessibility.

There are claims that several provinces are violating the criterion of portability. For example, in 1988 Quebec refused to sign the reciprocity agreement whereby other provinces would be reimbursed according to their own rates for services they provided to Quebeckers outside Quebec. Moreover, Canadians must increasingly resort to private insurance when abroad: Ontario, Saskatchewan, Alberta and British Columbia reduced their coverage for health care services obtained outside Canada. (However, the new Ontario government, elected in 1995, has re-established full coverage for care received outside this country). Some experts accuse the federal government of inaction in this area. They explain that the scope of the portability criterion is clearly defined in the Act, where the terms and conditions for reimbursement of out-of-province services are stipulated. This issue will undoubtedly have to be negotiated by the federal government and the provinces, if the principle of portability is to be preserved.

Likewise, some people believe the principle of comprehensiveness is not observed in practice, since all provinces do not necessarily cover the same basket of insured health care services or medically required services. They also believe that cutting government expenditures will compromise the principle of comprehensiveness even further and that the process of de-insuring begun in recent years could lead to the balkanization of provincial health insurance plans. Federal legislation defines only the major outline of insured services and leaves each province complete freedom to determine what services its public plan will provide. However, de-insurance emphasizes the gaps between provinces in their coverage of health care services; these discrepancies are likely to become increasingly difficult to justify. Moreover, de-insurance with the sole purpose of reducing public health expenditure could ultimately undermine the principle of free access inasmuch as it has not been proved which services are or are not medically necessary. This raises the thorny problem of how to determine when a service is medically necessary. It could

prove difficult to determine the limits of any list of medically necessary health services. Furthermore, it is hard to know how far the federal government can intervene in defining insured services, without encroaching on provincial jurisdiction. It will be interesting to watch the situation in the Maritimes, where the provincial governments have agreed to collaborate in drawing up a joint list of insured health services.

It can also be asked to what extent the Act permits delivery of health services by the private sector. In particular, there seems to be some controversy over whether private medical care runs counter to the principle of accessibility. In the letter to her provincial and territorial counterparts in January 1995, the federal Health Minister said she feared the proliferation of private clinics throughout the country would result in the long-term erosion of the public health system. She said she was pleased to note that the provincial Health Ministers had agreed, at their meeting in Halifax in September 1994, to cooperate to develop regulatory frameworks for private clinics; however, she was critical of the fact that Alberta's Health Minister did not intend to participate in this process. The government of Alberta repeatedly stated that public and private health care sectors can coexist without violating the Act. These differing interpretations of the legislation can be expected to intensify the debate throughout the coming months.

**With the coming into force of the CHST and its budgetary constraints, a number of provincial governments are questioning the concept of national standards. Transfers have dropped from $29.7 billion in 1995-96 to $26.7 billion in 1996-97. In addition, the federal government has again lowered the CHST for the following two years, to $25.1 billion. Starting in 2000-01 and until 2002-03, the growth in federal transfers will depend on the country's economic growth rate.**

F. The Options: Should We Keep the Act As It Is, Amend It or Repeal It?

The desire to reduce or stabilize the deficit is probably largely responsible for the current debate over national standards. Governments must make budget cuts and difficult choices in all their areas of responsibility, including health care. Since 1986, the federal government has limited the growth rate of EPF transfers paid for health. In addition, the CHST, the new form of block funding adopted by the federal government, will result in further cuts to transfer payments.

These restrictions result in decreased revenue for provincial governments, which must continue to be responsible for health care delivery. Any cut in government expenditures in the health sector will inevitably result in a challenge to the public sector's role in this area. Against this background, it has to be asked whether national standards can be maintained or whether it might not be wiser to amend the Act.

Some analysts believe the *Canada Health Act* should be kept as it is. They argue that any change in the fundamental principles on which health insurance is based would undermine the greatest achievements of the health care system in Canada. They also state that the reduction in EPF federal transfers and the pressure to contain the deficit should not be used to justify overhauling the Act. They believe that it is the health care distribution system, rather than the government health insurance plan, that needs an overhaul. They are convinced that national standards should be maintained, with the system reorganized to improve clinical and economic effectiveness. They believe that effective allocation of public funds, together with a more judicious use of staff and medical care, would enable the government to reduce overall public expenditure and fund a wide range of effective and necessary services. They favour the *status quo* to some extent, given that most provinces have already reformed their health care delivery system by focusing on greater efficiency. Some think the federal government should take a firm stance and enforce compliance with the national standards by using financial penalties rather than restricting its strategy to persuasion and negotiation. Others maintain that only stable and sufficient federal funding would encourage provinces, in other words an increase in transfers, would encourage provinces to ensure that their health insurance plans continued to comply with the criteria of the Act.

For a growing number of experts, however, the *status quo* is unacceptable. They say the *Canada Health Act* must be amended. Some suggest clarifying what is meant by "comprehensiveness" or "medically necessary services." Others recommend amending the Act to encourage the private sector's increased participation in either funding (user charges) or health care delivery (private clinics).

Those who believe the criterion of comprehensiveness in the Act is vague and imprecise point out that clarification in this area would produce many benefits. First, the services

for which the public sector must be responsible would be clearly set out; second, greater uniformity in the range of services throughout the country could be achieved, thus ending the balkanization of provincial health insurance plans. Clarification could also help define medical necessity, taking into account important factors, such as clinical, economic and ethical considerations. The Act could be clarified in three different ways. First, a definition of the term "medically required" could be added to section 2. Second, also in section 2, definitions relative to physician services, hospital services and extended health care services could be given. Third, the provisions in section 22 could be invoked, under which the federal government may establish by regulation (1) a definition of extended health care services, and (2) the list of hospital services that could be excluded from all insured services. The Act stipulates that such regulations cannot be made unilaterally, without the agreement of each province. However, there is no general agreement on these three options. Some analysts claim that until now the Act has given the provinces the latitude they need to interpret these terms in keeping with their own economic, political and social conditions. They believe that excessively specific definitions might limit the options of provincial governments to address the specific needs and values of their own residents.

The proponents of private fee structures favour the imposition of user charges for services covered by government health insurance plans. They explain that such action would help limit the abuse of health care by some patients, while reducing public expenditures on health. The effects of user charges on the use of health services and on public expenditures have been the subject of lively debate for some time and will not be discussed here. However, it should be pointed out that many analysts believe user charges are a step backwards, since the Act was adopted with the express purpose of discouraging such fees.

Other people favour increased use of private clinics, which, they maintain, improve accessibility and reduce costs. First, use of private clinics frees up hospital spaces for patients on waiting lists in the public system. Second, since the waiting period is shorter, the diagnosis can be made earlier and the related costs are thus lower. Moreover, the operating costs of a private clinic are less than those of a hospital. However, there is no general agreement on private clinics in Canada. In particular, it is widely feared that the establishment of private clinics would create a two-tier health system, in which low-income people would be denied access to good quality care.

The proponents of private clinics believe the *Canada Health Act* can be broadly interpreted as authorizing the establishment of such clinics. The opponents of private clinics suggest, however, that a sixth national standard be added to the Act--one expressly prohibiting the establishment of private clinics in Canada. The debate will likely continue throughout 1996, and legal opinions on the correct interpretation the Act must be obtained.

Finally some people believe the Act creates inflexibility: it limits the options available to provincial governments in their fight to reduce public expenditure and increase efficiency in the health sector. Their solution, which is undoubtedly the most radical, would be to repeal the Act. It is difficult to foresee the consequences of such an action. For example, it might have no effect: since the vast majority of Canadians are satisfied with the current system, pressure from voters might in itself be sufficient to force provincial governments to maintain the major principles of health insurance across the country. On the other hand, repeal of the Act might result in a large number of experimental systems in Canada; provincial health insurance plans would undoubtedly vary greatly, especially among provinces with very different tax bases.

The federal government has already made its position known. In passing Bill C-76 it has clearly indicated that the conditions attached to the Act will be maintained. Everything suggests that national standards will not be open to negotiation during federal-provincial consultations on the CHST.

## PARLIAMENTARY ACTION

In Canada, governments have intervened in the health sector in order to promote social and economic equity in this area. First with the adoption of the *Hospital Insurance and Diagnostic Services Act* in 1957, and then with the *Medical Care Act in 1966*, the federal government used its spending power to distribute funds and attach conditions it considered important, but without directly regulating a sector under provincial jurisdiction. By passing the *Canada Health Act* in 1984, however, Parliament did affect the provincial health insurance plans in that it imposed five key principles or national standards. This Act sets out some general rules that guarantee all Canadians access to medically necessary physician and hospital services, free of financial or other barriers, within a system publicly administered on a non-profit basis. These rules

also guarantee reimbursement for insured health care services received anywhere in Canada or abroad.

The national standards stipulated in the *Canada Health Act* are not new: they were already set out in previous legislation on medical and hospital care. What was new in the 1984 Act was the provision of penalties for defaults, that is, for the failure of provincial governments to comply, as part of their health insurance plan, with the criteria stipulated in the Act. Federal financial contributions made as part of the EPF, as well as other transfers to provincial governments, are conditional on the province's compliance with these criteria.

Over the past decade, the provinces have complied to a great extent with the criteria and provisions of the Act, although the federal government has had to intervene to ensure compliance with the provisions on extra-billing and user charges. The federal government has not, however, imposed penalties for failure to comply with the five main principles of health insurance. It has preferred to limit its action, at least so far, to persuasion and negotiation. Some people have criticized this approach and have referred to the federal government's inaction and inability to maintain national standards in practice. Given the division of powers between the two levels of government, it could have been expected that direct intervention by the federal government in this area might lead to conflict with the provincial governments and that warnings alone might be enough to secure the provincial governments' cooperation. In this respect, it will be interesting to observe the consultations on comprehensiveness scheduled for 1995 (in the Atlantic provinces) and on private health care delivery (in all provinces but one). It is also expected that the experts meeting as part of the National Forum on Health, chaired by the Prime Minister, will participate in the discussion on national standards. Lastly, national standards are certain to be discussed during the consultations on the CHST during the next few years.

Any proposal for reforming the *Canada Health Act* will inevitably have to consider factors that are constitutional (power sharing), political (feasibility and voter approval) and economic (expenditure control).

## CHRONOLOGY

1 April 1984 - The *Canada Health Act* received Royal Assent.

May 1994 - In accordance with the Act, the Governor in Council withheld $1,750,000 in EPF transfer payments from British Columbia because some medical practitioners in that province had withdrawn from the government health care insurance plan and resorted to extra-billing in 1993.

September 1994 - Federal/provincial/territorial meeting of Health Ministers in Halifax, Nova Scotia. All Ministers present, except the Alberta Minister, agreed to "take whatever steps are required to regulate the development of private clinics in Canada, and to maintain a high quality, publicly funded medicare system."

October 1994 - Official start of the National Forum on Health.

January 1995 - The Health Minister, the Honourable Diane Marleau, sent her provincial counterparts a letter informing them of the federal government's intention to impose financial penalties on provinces whose private clinics demand extra fees from patients in addition to the amount reimbursed by health insurance. The provinces have until 15 October 1995 to comply with this new interpretation of the Act.

June 1995 - Bill C-76, under which EPF transfers would be combined with CAP transfers to create a new form of block funding, received Royal Assent.

November 1995 - The Federal Minister of Health, the Honourable Diane Marleau, stated that the federal government had begun imposing cash penalties on all provinces in which semi-private clinics charged user fees. These provinces are Alberta, Manitoba, Nova Scotia and Newfoundland.

**April 1996 - The new CHST came into force, combining EPF and CAP transfers.**

**July 1996- Health Canada lifted the sanctions imposed on Alberta, when that province began complying with the Act.**

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